XXXXXXXXXXXXXXXX
DENTAC Patient Safety Officer

XXXXXX Dental Clinic

RISK MANAGEMENT PATIENT SAFETY

ONE CONCEPT OF PATIENT SAFETY:

HOW DO THESE TWO THINGS RELATE?

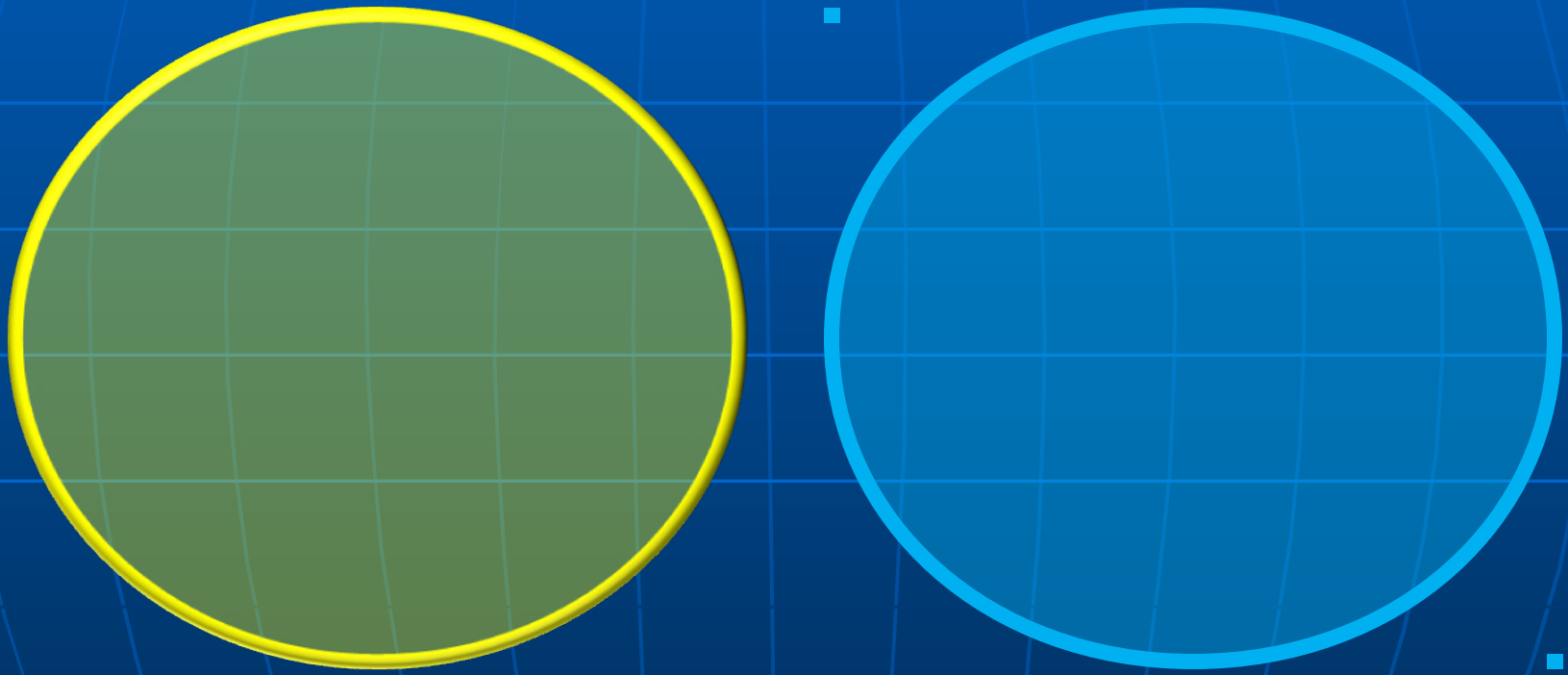
RISK MANAGEMENT

+

QUALITY

PATIENT SAFETY

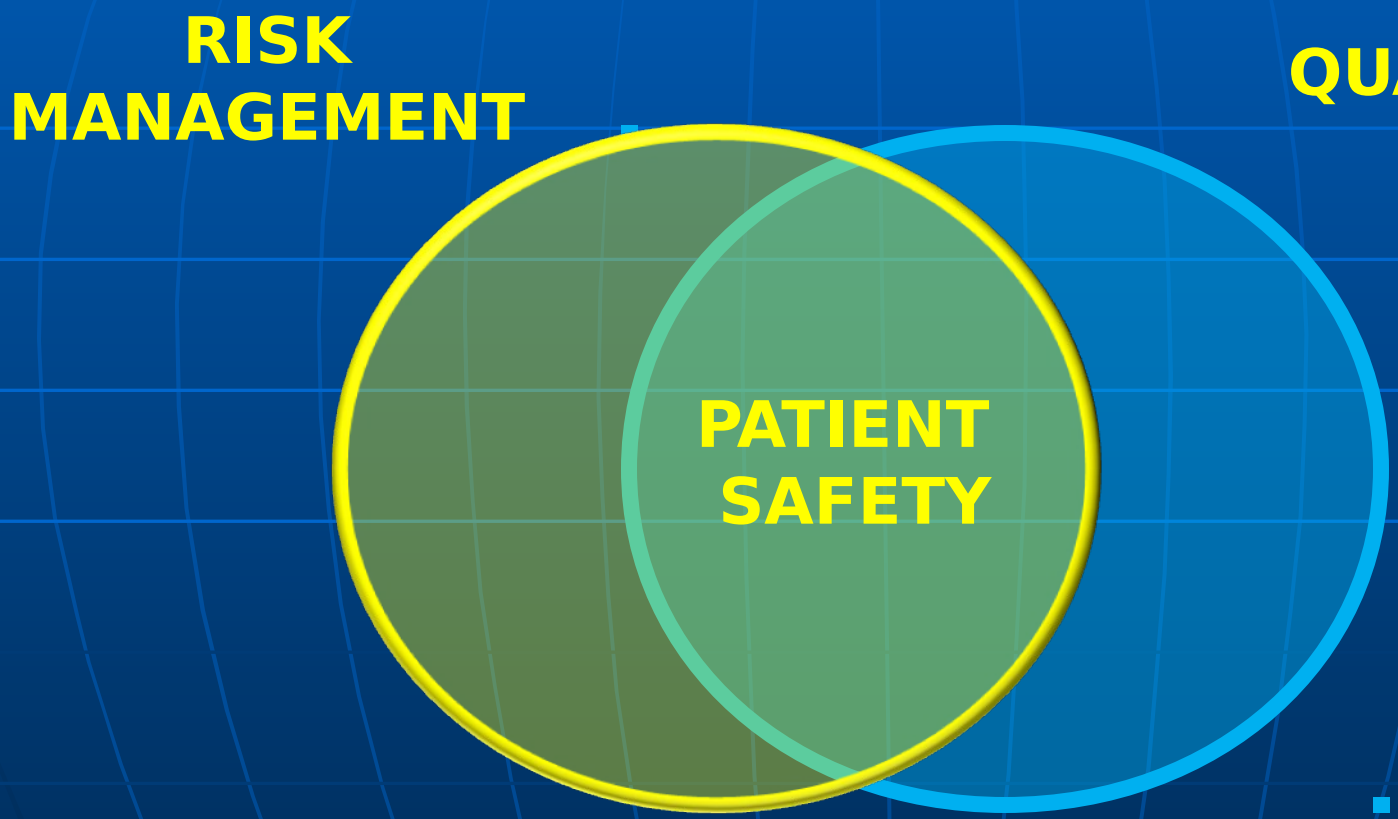
HOW DO THESE TWO THINGS RELATE?



RISK MANAGEMENT

QUALITY

HOW DO THESE TWO THINGS RELATE?



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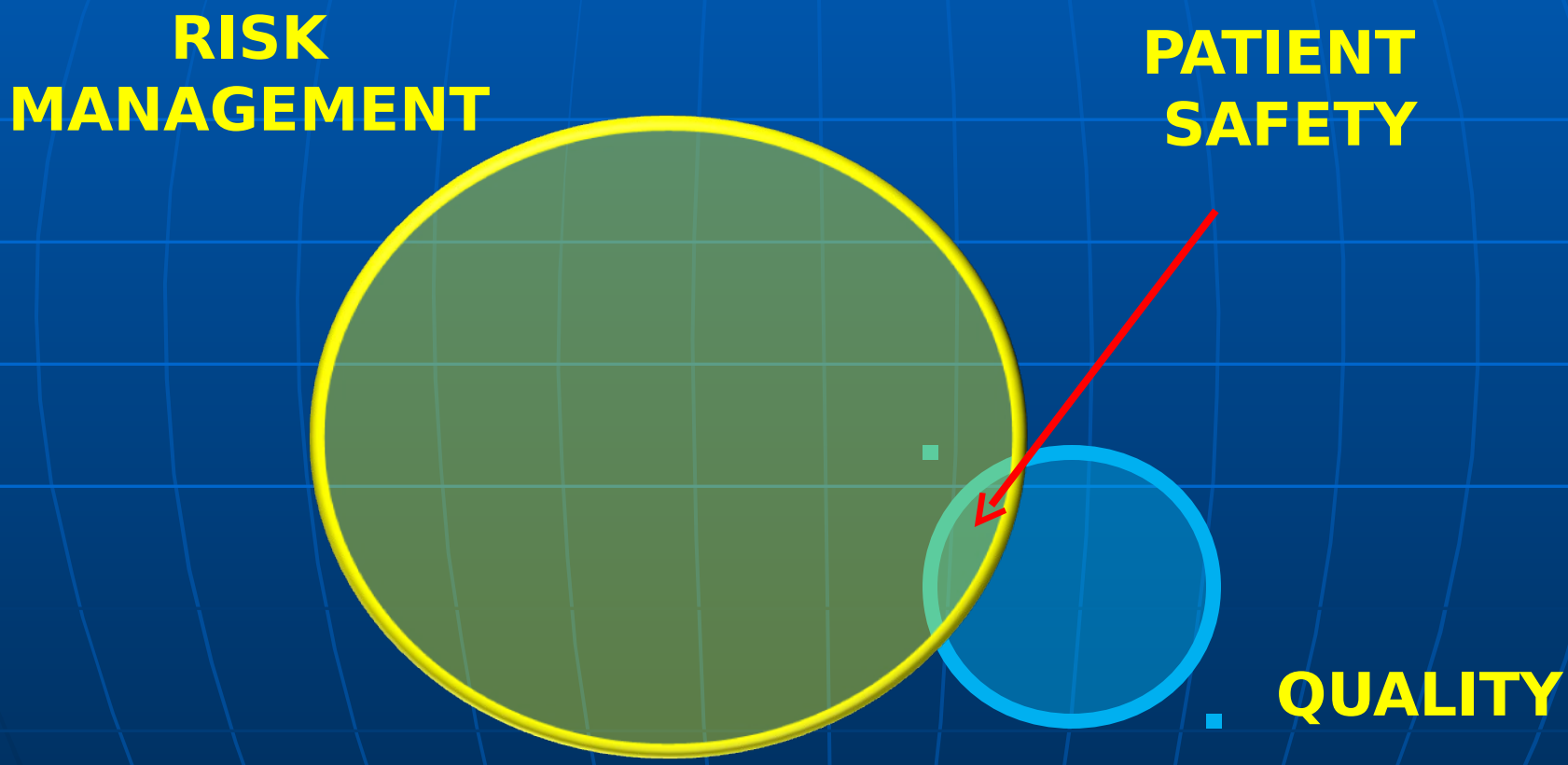

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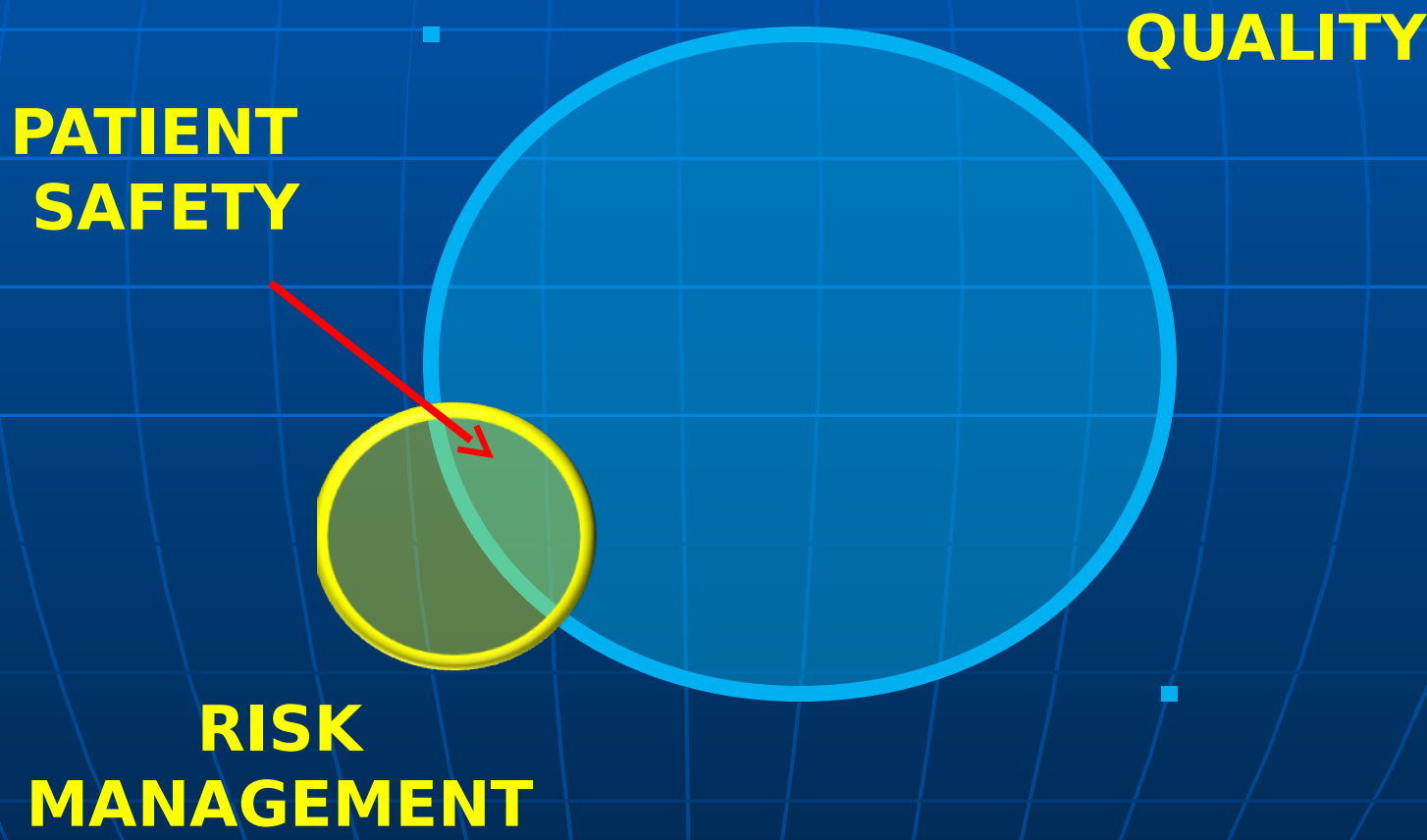
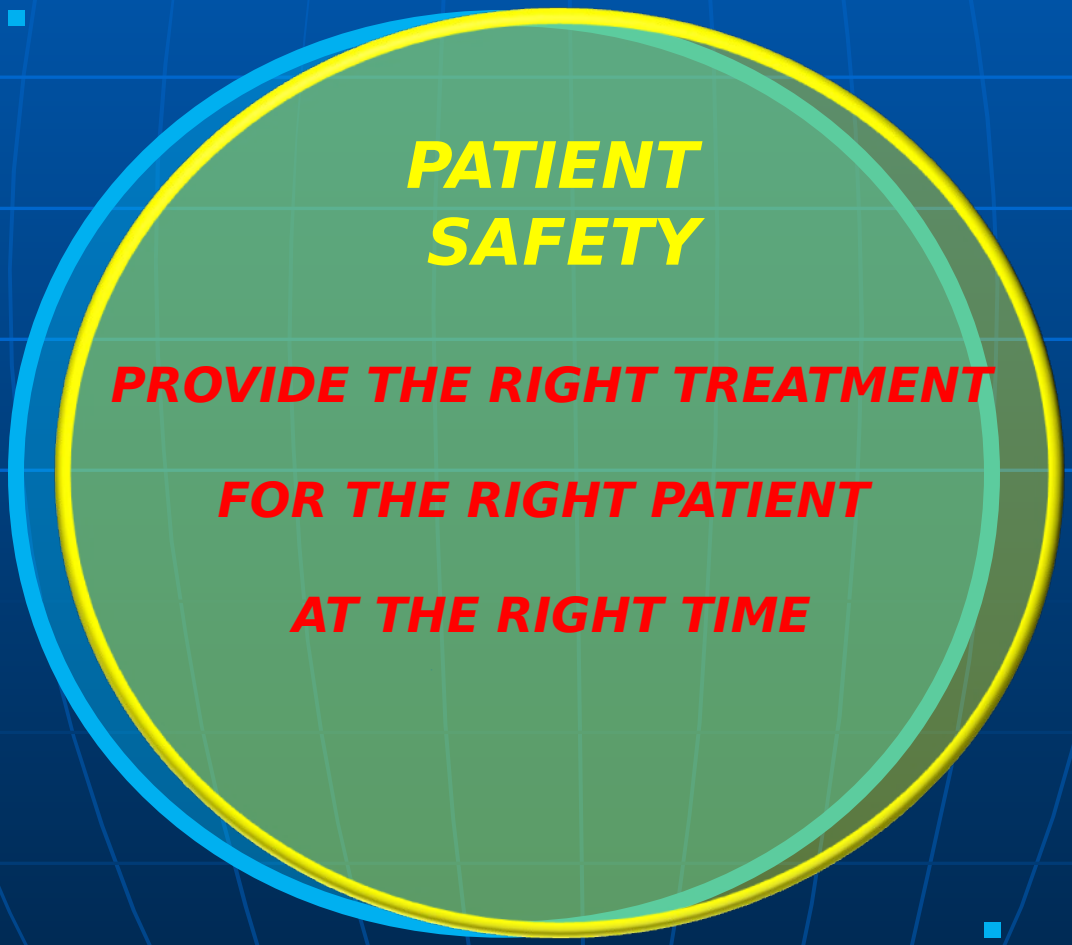


WHAT IS DENTAC'S PATIENT SAFETY GOAL?

RISK MANAGEMENT

QUALITY

WHAT IS OUR DENTAC'S PATIENT SAFETY GOAL?



Risk Management
What is it?

Facilities

Employees

Patient

"SAFETY" PERSPECTIVE

"PATIENT SAFETY" PERSPECTIVE

Risk Management
What Is It?

- *Risk = Chance of loss*
  - Monetary
  - Injury
  - Patient confidence/compliance
  - Employee confidence/compliance/loyalty
  - Intangible components

Risk Management
What Is It?

- *<u>Organizational</u>:* ***DENTAC decides*** *how to minimize or avoid loss* ***for you***

- *<u>Individual</u>:* ***You personally decide*** *how to minimize or avoid loss*

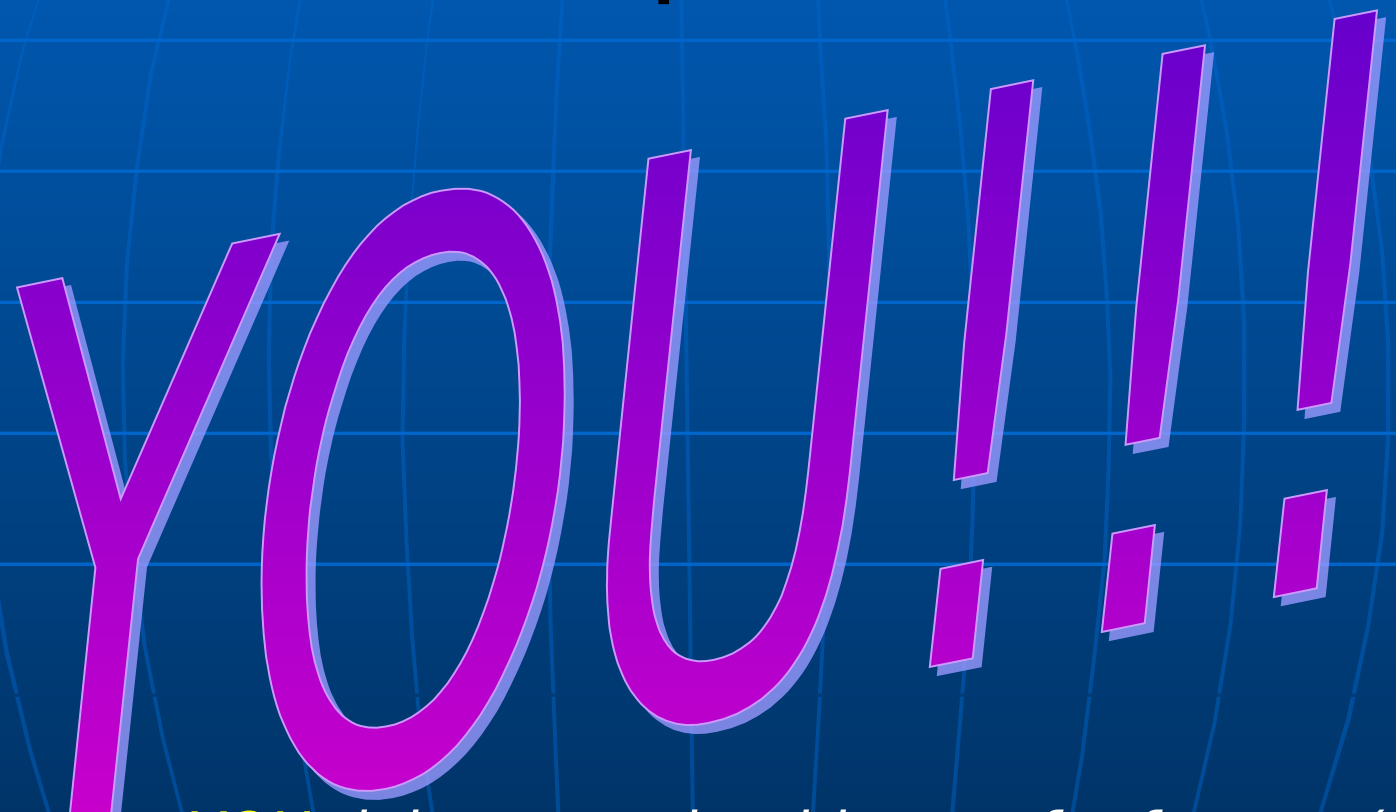
Risk Management
Who is responsible?

- *Commanders*
- *OICs*
- *NCOICs*
- *Providers*
- *Employees*
- *Maintenance staff*

EVERYONE

Risk Management

Who is responsible?



What are YOU doing to make things safer for you (as an employee) and your patients?

Risk Management
How do "I" find risky situations?

- *Be alert for situations or actions which can result in loss*
  - Unusual occurrences - Patients
    - Death
    - Patient returns for same problem same area
    - Wrong patient/wrong record
    - Wrong site treatment – *"Wrong Site Surgery"*
      - Fill/treat wrong tooth, wrong area
      - Extract wrong tooth
    - Unsafe practices
    - Adverse reaction to medication
    - Injury - Falls, cuts, bruises

Risk Management
How do "I" find risky situations?

- *Look for situations/actions which can result in loss for you or others*
  - Unusual occurrences – Self/Employees
    - Sharps injury
    - Blood-borne pathogen exposure
    - Needle-sticks
    - Occupational Illness/Injury
      - Falls, sprains, etc.

Risk Management
How else do "I" find risky situations?

- *Learn more*
  - Use training to really learn – Don't just *"show up"*
  - Learn and use what you learn from training *TeamSTEPPS,* OPD, NCOPD, CDR's Call
- *Look for ways to reduce risky situations*
- Near Misses
- Actual incidents
- Engage in peer review
- Review DoD/CQ logs
- Complete and learn from drug audits
- Learn from Safety and patient safety reports
- Perform standard of care reviews when possible

Risk Management

How else are risky situations identified?

- *Safety checks done often…*
  - People
    - Providers qualifications/skills evaluated continuously
      - Patient evaluations / customer service
      - Peer review/recommendations
      - Credentialing/Privileging
      - Drug audits
      - Random urinalysis
    - Staff
      - Performance evaluations
      - Re-certifications, i.e. CPR

Risk Management

How else are risky situations identified?

- *Safety checks done often… (Cont'd)*
  - Facilities
    - Equipment
      - Safety checks
      - Routine maintenance
    - Environment
      - Industrial hygiene inspections
- *When something serious does occur, DENTAC investigates to see what can be improved to reduce risky situations in the future*

ROOT CAUSE ANALYSIS REPORT TO THE COMMANDER

XXXXXXXXXXXXXXXXXX Incident

DENTAC Headquarters

XXJUNXX

ROOT CAUSE ANALYSIS "RCA"

Formal investigation surrounding an adverse event involving a patient

- *Patient sustained temporary or permanent*

DENTAC XXXXXXX Root Cause Analysis Timeline

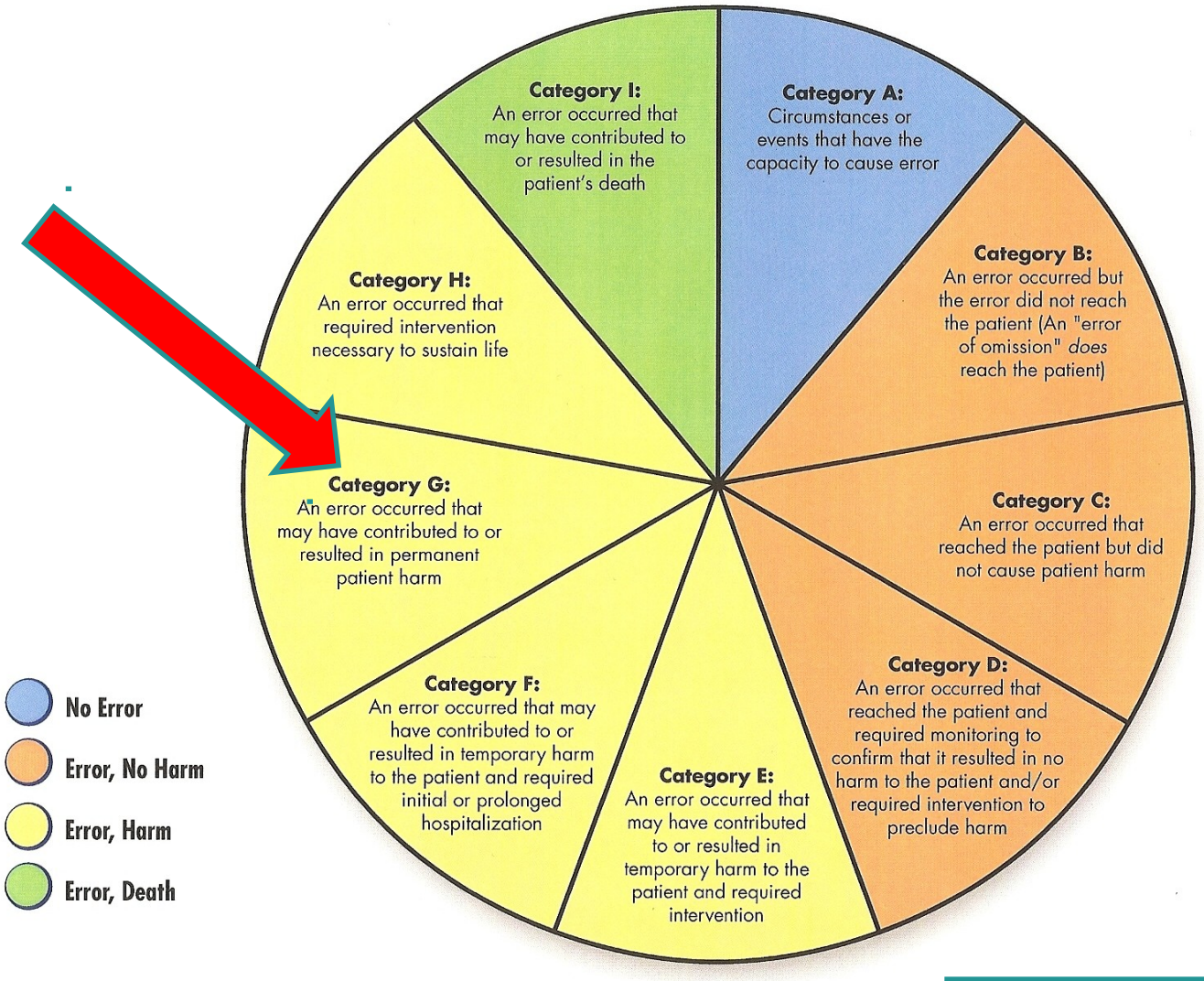
- *Timeline*
  - 27JUNXX – Adverse event occurred @ X DC
  - 30JUNXX - DENTAC made aware of event
  - 04JULXX - Informal findings presented to QA Committee
  - 05JULXX - RCA Team Chartered
    - COL A (Leader)
    - COL B (Member)
    - CPT C (Member)
    - Mr. Smith (Advisor)
    - LTC Xcellent (Consultant)

DENTAC XXXXXXXX Root Cause Analysis Timeline

- *Timeline (Continued)*

  - 09JULXX – RCA Team meeting
    - Received Just-in-time RCA training
    - Evaluated case documentation
    - Reviewed Correct Site Surgery Policy (40-46)
    - Deliberated
    - Created report and action plan
  - 12JULXX – RCA final report presented to DENTAC CDR
  - 15JULXX – RCA final report forwarded to Regional Commander then to MEDCOM Patient Safety Center

NCC MERP Index for Categorizing Medication Errors


Category I:
An error occurred that may have contributed to or resulted in the patient's death
Category A:
Circumstances or events that have the capacity to cause error
Category B:
An error occurred but the error did not reach the patient (An "error of omission" *does* reach the patient)
Category C:
An error occurred that reached the patient but did not cause patient harm
Category D:
An error occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to preclude harm
Category E:
An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention
Category F:
An error occurred that may have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization
Category G:
An error occurred that may have contributed to or resulted in permanent patient harm
Category H:
An error occurred that required intervention necessary to sustain life
No Error
Error, No Harm
Error, Harm
Error, Death

Definitions

Harm
Impairment of the physical, emotional, or psychological function or structure of the body and/or pain resulting therefrom.

Monitoring
To observe or record relevant physiological or psychological signs.

Intervention
May include change in therapy or active medical/surgical treatment.

Intervention Necessary to Sustain Life
Includes cardiovascular and respiratory support (e.g., CPR, defibrillation, intubation, etc.)

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Incident rated Category F or higher:
RCA warranted

Root Cause Analysis Determination

- *Root Cause Determination:*
  - Communication breakdown between staff members
  - Human performance error significantly contributed to this adverse (sentinel) event

- *Other potential causes were ruled out by the RCA process*

Root Cause Analysis Additional Findings

- *Incomplete or erroneous documentation displayed in many dental record entries surrounding this incident include:*
  - No time out
  - No diagnosis or justification for extraction(s)
  - Procedural details minimal
  - No pre-operative or post-operative blood pressure readings
  - Incorrect tooth numbering
  - No time of appt
- *Existing documentation deficiency could significantly contribute to adverse events in the future*

Risk Management
How do "I" put this into action?

- *Communicate!*
  - If you see something risky, do something to interrupt it
    - If you can't do it, get someone who can (Supervisor / NCOIC/OIC)
  - Report what you see and know is happening
    - DA 4106 (Near miss and actual event incident report)
    - Safety Reports
    - CA1/CA 16 (civilian employees)
- *Get involved with our patient safety program*
  - Our patients are counting on you to do everything you can to help them
- *Investigate (if in a position to do so)*
  - Root Cause Analysis
  - Line of duty investigations
  - Quality Improvement investigations

Risk Management
How do "I" put this into action?

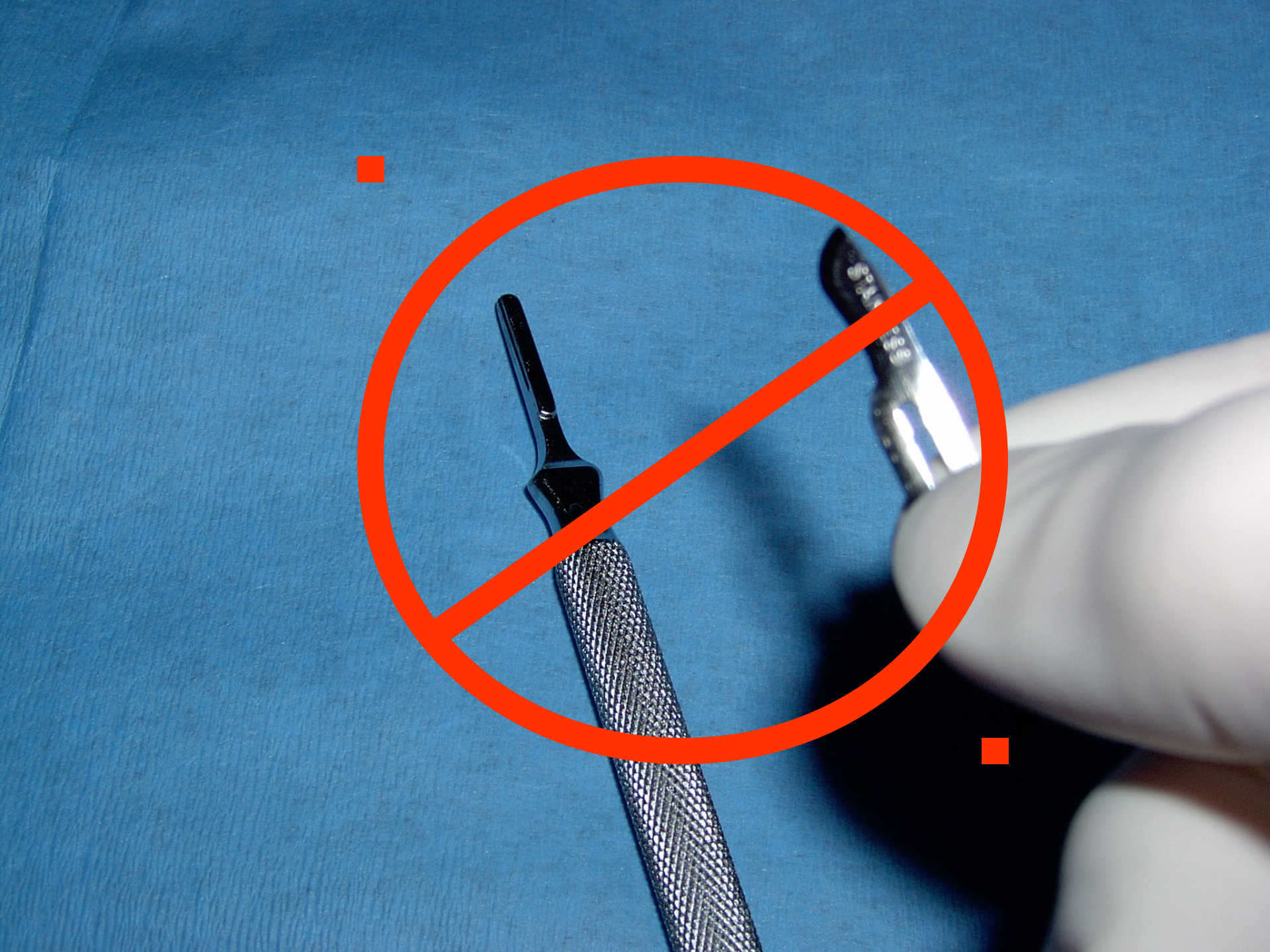
- *Understand your role in looking for and responding to risky situations*
- *Accept this very important role*
- *Look for ways to address what you find*
  - Next few slides show a response to something risky

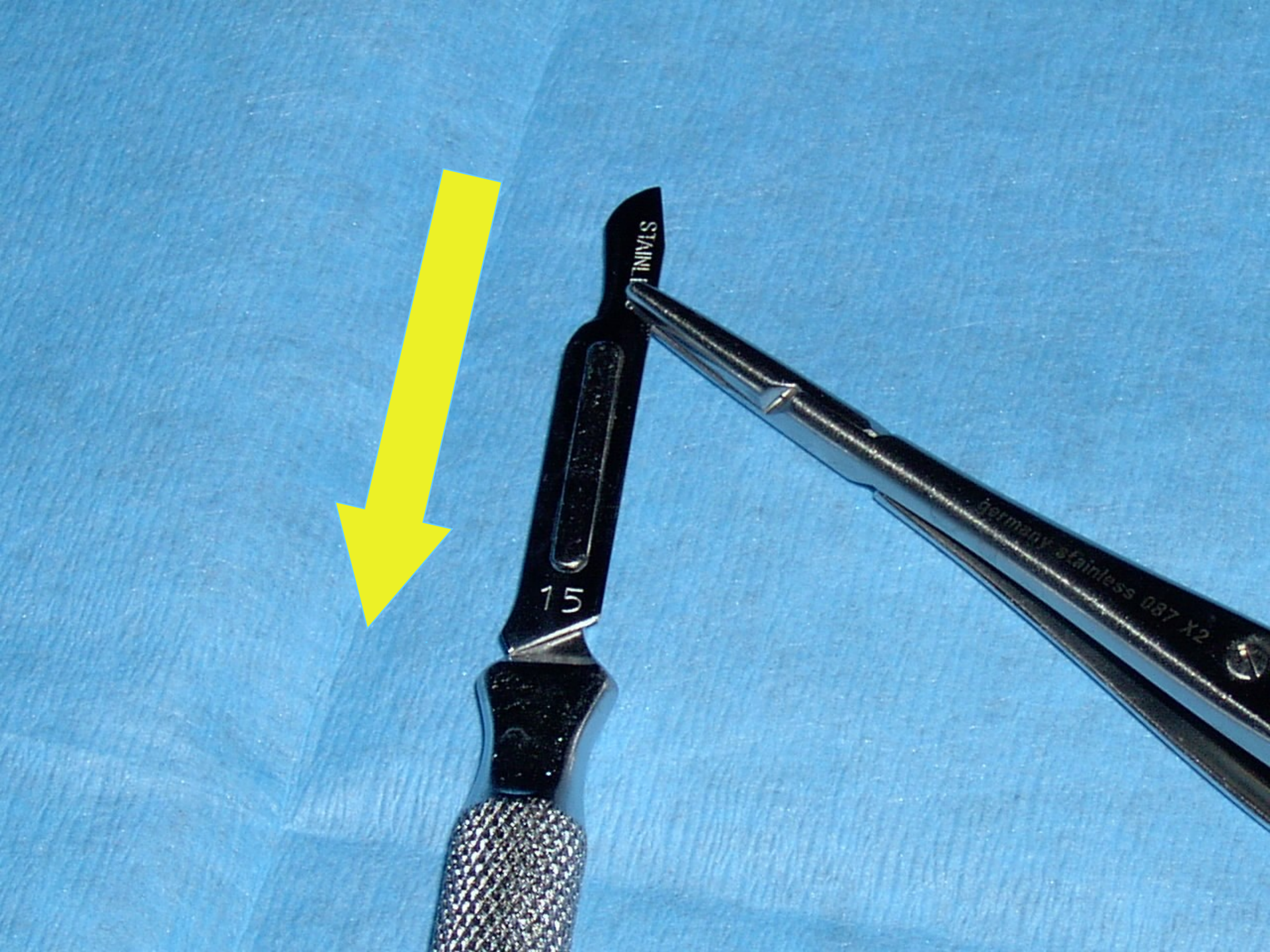
What is wrong with this picture?

Touching a blade or sharp instrument is a very UNSAFE PRACTICE!!!

What should we do when we see an UNSAFE PRACTICE?
Do something about it!
Speak Up
Interrupt behavior
Educate

BLADE + FINGERS = INFECTION

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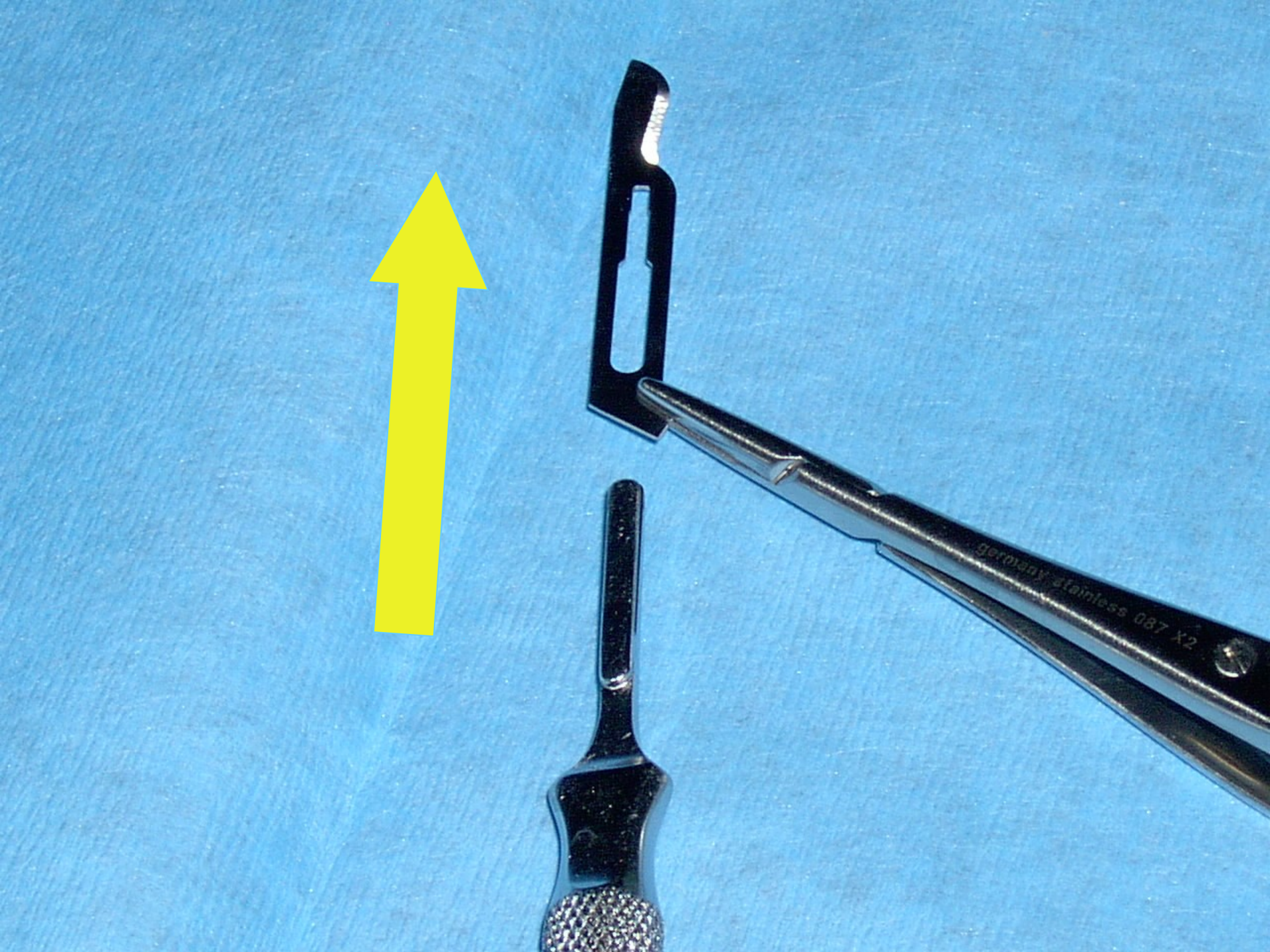
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Which Finger Do YOU Want?

Risk Management
How do "I" put this into action?

- *Employees*
  - Ensure competency for procedure at hand for self and staff
  - Obtain appropriate training for the position you and your staff are in
  - Provide training for others if able to do so
  - Be aware of ergonomics for self and others
  - Notice and address potential injury producing situations
  - Use ***TEAM APPROACH*** – Stop at-risk events ON THE SPOT!

Risk Management
How do "I" put this into action?

- ***Facilities***
  - Ensure all equipment is working properly and speak up if it is not, i.e. Work order
  - Minimize access to unauthorized personnel, i.e. Close outside doors
  - Ensure building/operatory is in good condition
    - Minimize tripping/falling hazards
      - Cords are managed
      - Sidewalks are clear
      - No standing water on floors
    - Clear operatories of "clutter"
    - Standardize operatories

Risk Management
How do "I" put this into action?

- *Patients – Clinical Interaction*
  - Patient education
    - Ensure patient fully understands their dental condition and specific treatment options
    - Informed consent (risks/benefits)
  - Documentation – 603/603A entries
    - Comprehensive entries in dental records
    - Informed consent (risks/benefits) OF 522

PATIENT SAFETY
What is it?

Facilities

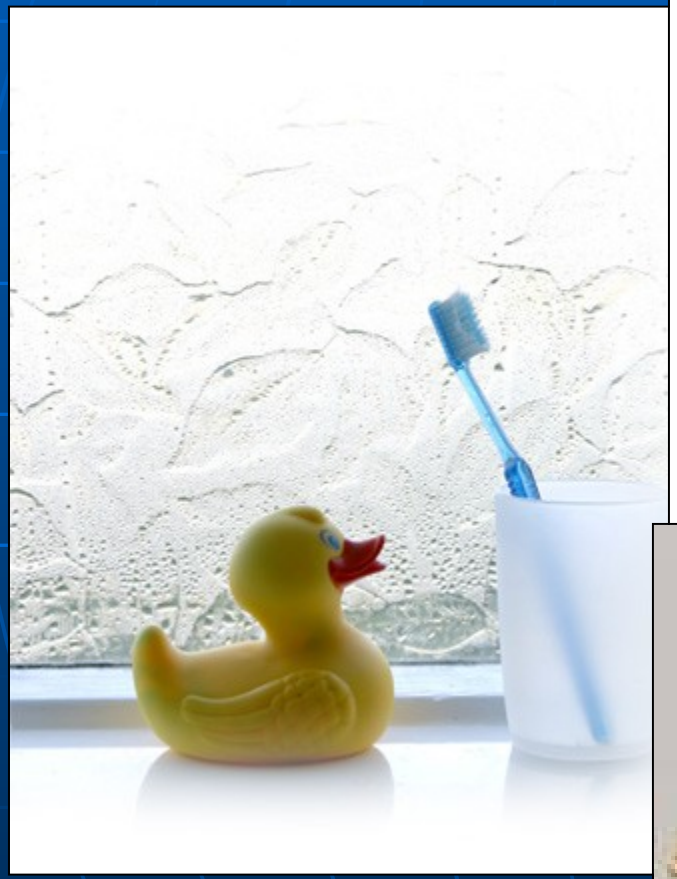
Employees

Patient

"SAFETY" PERSPECTIVE

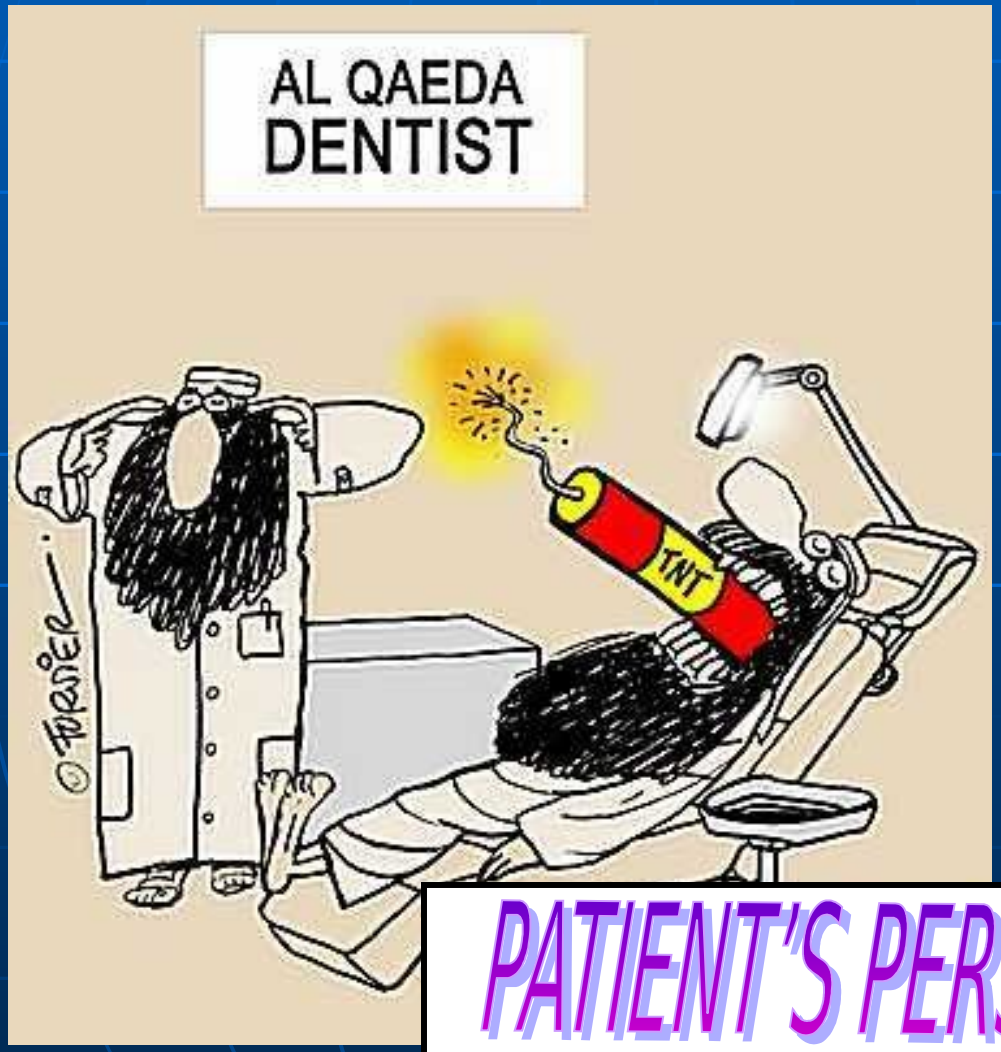
"PATIENT SAFETY" PERSPECTIVE

IDEAL DENTAL EXPERIENCE



EVERYONE IS HAPPY!!!

DENTAL EXPERIENCE
IDEAL MEETS OUR REALITY



PATIENT'S PERSPECTIVE

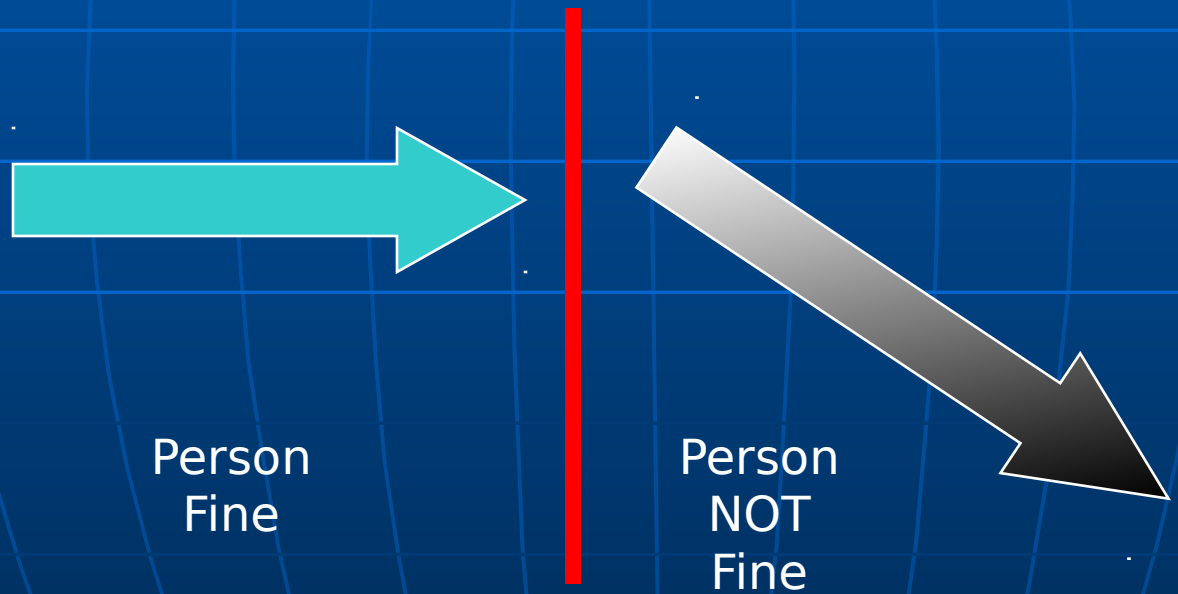
Patient Safety
What is it?

- ***Patient Care***
  - Patients have a right to freedom from accidental or preventable injury

- ***Providers and Staff: Have an opportunity to make a difference in patients enjoying that right***
  - Before - Proactively minimize likelihood of errors
  - Just Before - Intercept errors BEFORE they are about to occur
  - During – Intercept errors as they occur
  - After
    - Acknowledge errors occurred
    - Look for ways to eliminate error cause in future

MEDICAL EMERGENCY
What Is It?

- *Acute life-threatening situation*

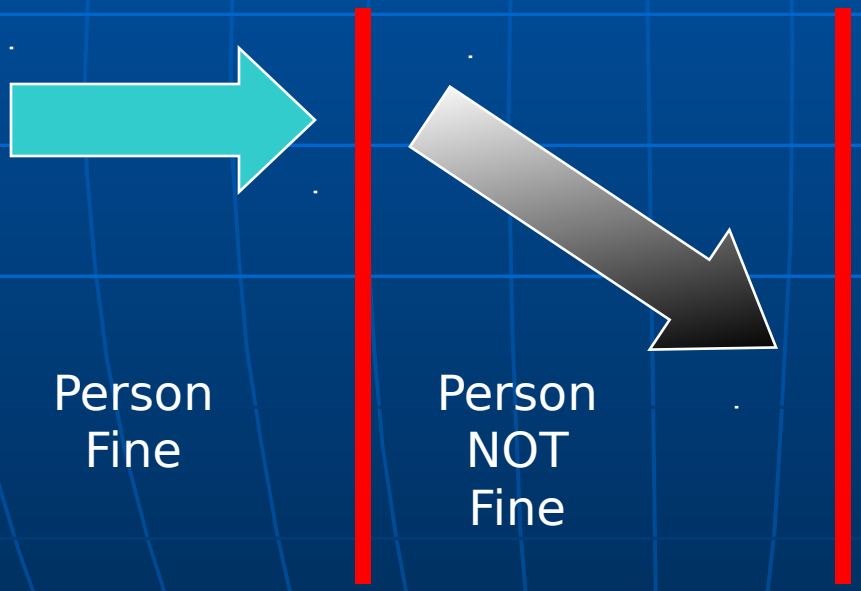


MEDICAL EMERGENCY
Why Worry Here?

- *Acute life-threatening situation*

MEDICAL EMERGENCY
Why Worry Here?

- *Acute life-threatening situation*



?????

OUTCOME MAY BE UP TO YOU!!!

Patient Safety
What are some "common" dental errors?

- *Wrong tooth removed or treated*
  - Handwriting illegible
  - Charting incorrect/reversed
  - Exam and/or documentation incomplete
  - Non-diagnostic radiographs
  - Reversed radiographs

Patient Safety
What are some "common" errors?

- *Injury from faulty instruments*
  - Poorly operating high-speed hand-piece
  - Dull bur
  - Clogged lines prevent water flow
- *Improper sterilization techniques*
- *Inappropriate medication prescribed*
- *Inappropriate anesthetic*
- *Inappropriate dosage administered*

Patient Safety
How do I combat common errors?

- *Medication errors*
  - Review health questionnaire EVERY TIME
  - Review medical history at least biannually
  - Prescriptions
    - Identify current meds and check for interactions
    - Use CHCS for all Rx
    - Call pharmacy if you need clarification
  - Seek assistance from another provider if unsure

Patient Safety
How do I combat common errors?

- *Remove or treat wrong tooth*
  - Perform Time Out properly
  - Confirm patient identity
  - Confirm correct record
  - Require and obtain diagnostic radiographs
  - Review and double check dental record
  - Call referring provider if unclear/unsure

Patient Safety
How do I combat common errors?

- *Faulty Equipment*
  - Keep maintenance logs
  - Daily/weekly equipment checks
  - Proper routine maintenance
  - Take defective equipment out of service

Patient Safety
How do I combat common errors?

- *Improper sterilization*
  - Ensure spore testing is being done properly
  - Ensure event-related sterilization
  - Ensure proper handling and packaging
  - Use PPEs
  - Use barriers

Patient Safety Summary

How can I ensure patient safety?

- *Do the right thing*
  - At the right time
  - All the time
- *Be alert*
- *Focus on your patient*
- *Be aware of your surroundings*
- *Realize how very important YOU are in meeting OUR MISSION*